INDEX OF SURGICAL PROGRESS.

ABDOMEN.

I. Pyo-Stercoral Fistula Cured by Enterorrhaphy. By Prof. TRÈLAT (Paris). A pyo-stercoral fistula is a more or less irregular channel running between the intestine and the external surface of the body, and giving passage to pus and fæcal matter or to pus alone. It is to be distinguished from a fæcal fistula or an artificial anus by the presence of a suppurating cavity between the intestine and the external opening.

Pyo-stercoral fistulæ are rare. The chief causes, in order of frequency, are iliac abscess, perityphlitis, abscesses with escape of intestinal worms, periuterine inflammations and perinephritic abscesses. The intestinal perforation generally occurs before the skin is perforated. From a clinical point of view these fistulæ are distinguished by their slow formation and long duration, and also by the fact that from time to time they appear to be perfectly healed, only, however, to break down again in no long time. When death occurs it is generally from retention, hectic, etc. Peritonitis is rare as a cause of death.

As regards treatment, the only method which offers a certain chance of cure is suture of the intestinal opening, but unfortunately this cannot be practiced in those cases where there is more than one fistulous passage into the intestine, and where the intestine itself is so bound down by adhesions that it cannot be freed. These secondary fistulous tracts are generally the result of treatment; naturally there is as a rule only one tract. In those cases where enterorrhaphy cannot be performed M. Trèlat recommends Verneuil's treatment, viz., to lay the abscess cavity open and cauterize freely in the hope that the ensuing cicatricial changes may so mend matters that enterrorhaphy may eventually be performed. Failure of the suture is inevitable unless the intestine can be entirely freed from adhesions.

Umbilical pyo-stercoral fistulæ and those resulting from perinterine inflammations are the most difficult to treat satisfactorily; the former on account of the long and often complicated track of the fistula, the latter from the presence of extensive adhesions.

J. ANDERSON SMITH (LONDON).

II. Acute Stricture of the Ileo-Cæcal Valve. By PERCY POTTER (London). Female child, æt. 5, obstruction for a week. Abdomen flattened and specially tender over right iliac region. Left decubitus with thighs flexed. Temperature not raised. Vomiting persistent, not fæcal. Laparotomy. Nothing found except distention of small intestines and collapse of large. Death six hours afterwards. Necropsy, seventeen hours after death: The intestines being removed and filled with water, it was found that the ileo-cæcal valve was impervious, even to fluid. The lower few inches of the ileum were the seat of enteritis; flakes of inflammatory lymph had agglutinated the edges of the valve to such an extent that close inspection discovered only a pin hole opening, through which water could percolate drop by drop. No foreign body in the vermiform appendix, nor anything found in the intestines likely to have caused inflammation of the mucous membrane.—*Brit. Med. Jour.*, Nov. 10, 1888, p. 1045.

C. B. KEETLEY (London).

III. Case of Ileo-colic Invagination; Spontaneous Elimination of Gangrenous Bowel; Recovery. By Dr. OBTULOWICZ (Buczacz, Austrian Poland). A boy, æt 13, when climbing up a tree, suddenly felt a violent pain about his right iliac region, shortly followed by bloody stools. By the end of two weeks (during which he remained in bed, suffering from colics and bloody diarrhœa) he noticed a tumor about the said region. A week later he passed with stools a piece of dead bowel, 20 cent. long, consisting of the whole cæcum with its appendix and an invaginated portion of the ileum with a fragment of the mesentery. The boy made a good, though rather slow, recovery and remained apparently well for a minute, until he met with another accident, namely, he happened one day to drive a carriage with two horses; the latter took fright; when trying to stop

the animals; he suddenly felt a severe pain about the right hypochondrium. After a twelve months' illness he died, the cause seemingly being fœcal extravasation.—*Wiadomosci Lekarskie*, Oct., 1888.

VALERIUS IDELSON (Berne).

IV. On Perforation of the Vermiform Appendix in its Relation with Attacks of Peri-typhlitis. By JOHN A. MACDOUGALL, M.D., F.R.C.S. (London). In this paper Dr. Macdougall discusses the various causes of perityphlitis, mentioning chill, indigestion and muscular exertion, and most important, the presence of concretions and foreign bodies in the appendix. A very great many of the cases of perityphlitis are due to perforation of a foreign body, and he thinks in no small number of these nature, through adverse circumstances, fails to form a protective barrier of lymph, and a general and rapidly fatal peritonitis develops. He then points out what symptoms may aid the medical man in judging when perforation has taken place. Pain is very important; for although it occurs in perityphlitis and is at times severe, yet it is not so sudden in its onset nor so agonizingly acute as in perforation. It is often fixed at a distance from the tone spot; at times being referred to the umbilicus or epigastrium. Vomiting is often present, but not continuous. The temperature, although in peri typhlitis ranging between 101° and 103° or 104°, rarely exceeds 101° when perforation has taken place. The rapid formation of an iliac tumor would also be suggestive. Given, then, a case in which with a previous history of recurrent iliac pain there is an attack of *intense* pain in the abdomen, having, it may be, close association with the taking of food, attended by vomiting, and probably rigor, with very early tenderness on pressure in the cæcal region, and a sense of resistance with modified dulness on percussion, with comparatively little febrile reaction, and with the formation of a distinct and very tender tumor in the iliac fossa, what is the wisest plan to follow? The difficulty lies in the uncertainty of diagnosis. If the attacks began with collapse and signs of general peritonitis, the rule would be to wait until the patient had rallied a bit and then to open the abdomen. General peritonitis appears from the second to the fourth day. Of course any fluctuation in the tumor or evidence of pus by aspiration

would at once decide. Most of these cases perish during the first week, so that action to be of use must be ready. Fifty favor operation on the third day, but Dr. Macdougall would not operate quite so early, believing that a day or two more gives time for adhesions to form, and thus enhance the success of the operation. When early operation is decided on a median incision is the best, supplemented, if necessary, by an opening in the iliac region. The disease can also well be reached by a free incision similar to trying the common iliac artery. Dr. Macdougall, in concluding, predicts that here, as elsewhere in surgery, the percentage of success in operative interference will grow larger as our skill in diagnosis improves. *Lancet*, Sept. 29, 1888.

V. On the Diagnostic Value of "Ballooning of the Rectum" in Cases of Stricture of the Bowel. By THOS. BRYANT, F.R.C.S. (London). Mr. Bryant attaches great importance to ballooning of the rectum in cases of stricture beyond the reach of the surgeon's finger. In the normal condition the walls of the rectum are in contact. When stricture exists, the surgeon finds that after his finger has passed the sphincter it enters a cavity—the rectum which is "ballooned." The finger can move about quite freely, and the walls can only be felt when searched for. Mr. Bryant has never found this condition to be present in other cases than those of stricture. He believes the "ballooning to be brought about primarily by atrophy of the muscular walls due to the absence of peristaltic movement owing to the stricture; secondarily to the distension of the atrophied bowel by retained flatus. It is probable, however, that in some cases at any rate, there is no flatus to aid the distension. It is not present in all cases of stricture, especially those of rapid development. Mr. Bryant states that it has many times enabled him to confirm a doubtful diagnosis, or to make one in which much doubt has existed previously.—*Lancet*, January 5, 1889.

VI. Sigmoid Colotomy as a Method of Treatment in Rectal Carcinoma. By T. F. CHAVASSE (Birmingham). The indications for sigmoid colotomy in rectal carcinoma are: 1. When

great pain exists during the act of defæcation, or when urgent tenesmus is constant. 2. For obstruction due to narrowing of the calibre of the bowel by the growth of the neoplasm. 3. For the relief of recto-vesical or recto-vaginal fistula. Mr. Chavasse performs the operation in the usual way. He passes a thin piece of silver wire through the two outer coats, about the middle of the protruded bowel as a guide for the second part of the operation. The advantages he claims for the operation are: 1. It is readily performed. 2. The patient can dress the wound himself. 3. The patient is able to lie on his back without discomfort. 4. Four or five inches more of the colon are left to perform its duties. 5. Being nearer the seat of the disease the operator is able, if necessary, to ascertain the precise limits of the growth. 6. The wound in the soft parts being small and superficial readily heals. Mr. Chavasse also states that he has never seen prolapse in the inguinal operation. There is no doubt that prolapse is far more common in this operation than in the lumbar method. Mr. Herbert Allingham says that the amount depends very much on the length of the sigmoid mesentery. With regard to making a spur, Mr. Chavasse would do so if the obstruction were not complete, but not if the obstruction were complete. Now Mr. Herbert Allingham maintains that the latter are just the cases where a spur should be made, as the fæces get into the cul-de-sac and set up ulceration and other troubles. When the obstruction is incomplete they can be washed away by syringing through the wound and annus. Also when the bowel is distended, the operation is more likely to be followed by peritonitis owing to the difficulty of fixing it to the abdominal wall, and it is also much easier in such cases to perform the lumbar operation.—*Lancet*, 5, 1889.

H. H. TAYLOR (London).